

## **Advance Directive** **including Power of Attorney for Health Care**

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### **Overview**

This is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a Power of Attorney for Health Care and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **health care agent**. This document gives your health care agent authority to make your decisions *only when you have been determined incapable by your physicians to make them*. It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your health care agent.** If you do not closely involve your health care agent, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

## **NOTICE TO PERSON MAKING THIS DOCUMENT**

**YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.**

**BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.**

**IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.**

**THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.**

**YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.**

**DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.**

**IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.**

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## Part 1: My Health Care Agent

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable of making health care decisions as provided under Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

*When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).*

*Your health care agent must be at least 18 years old and may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative. You may also designate an alternate and second alternate health care agent.*

### The person I choose as my health care agent is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Second choice (alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Third choice (2nd alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

Check here if you do not have an agent, and wish for your physician to follow the instructions below.

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## Part 2: General Authority of the Health Care Agent

### I want my health care agent to be able to do the following:

Draw a line through (e.g., ~~Arrange for~~) anything listed below that you do **not** want your health care agent to do.

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment already has been started, my health care agent can keep it going or have it stopped based on my stated instructions or my best interests.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state, as my health care agent thinks is appropriate.
- Determine which health care professionals and organizations provide my medical treatment.
- Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

### Limitations on Mental Health Treatment

Pursuant to Wisconsin statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

To complete the next 3 sections:

Initial or check the box beside one statement in each section. If you do not mark any box in a section, your choice is "no" according to Wisconsin statute. This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

### 1. Admission to a Nursing Home or Community-Based Residential Facility

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

**Yes**, my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

***Unless I choose "yes," I can be admitted to a long-term care facility for a long-term stay only with a court order.***

### 2. Withholding or Withdrawal of Feeding Tube

**Yes**, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

***Unless I choose "yes," a feeding tube can be withdrawn or withheld from me only with a court order.***

### 3. Health Care Decisions during Pregnancy

**Yes**, my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to make health care decisions for me if I am pregnant.

***Unless I choose "yes," health care decisions during pregnancy can be made for me only with a court order.***

**Does not apply**. I am either a male or no longer capable of becoming pregnant.

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## Part 3: Statement of Desires, Special Provisions, or Limitations

***You are not required to provide any instructions or make any selections in this section.***

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

### Instructions Regarding Life-Prolonging Treatments

*Initial or check the box beside the statement or statements you agree with.*

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my health care agent to:

- Stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including intravenous (IV) hydration, respirator/ventilator, and cardiopulmonary resuscitation (CPR). If I suffer this type of condition, in my view, the potential benefits of supportive medical treatments are outweighed by the burdens of those treatments.
- Continue or start feeding tubes including intravenous (IV) hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator and cardiopulmonary resuscitation (CPR).
- I want my agent to be able to make decisions for me about life-sustaining treatment.
- Follow my instructions as provided below.

### Pain and Comfort

*Initial or check the box beside this statement if you agree.*

- If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

**The following are important to me for comfort** (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible):

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## Cardiopulmonary Resuscitation (CPR)

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. **If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency.**

*Initial or check the box beside the statement you agree with.*

I want CPR attempted **unless** my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

I do not want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

### **Other instructions or limitations I want my health care agent to follow:**

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### **When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:**

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### **If I am nearing my death, I want the following:**

*List the type of care, ceremonies, etc. that would make dying more meaningful for you.*

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### **Person or people I want my health care agent to include when making health care decisions:**

I ask that my health care agent make a reasonable effort to include the following person or people in my health care decisions if there is time: \_\_\_\_\_

## Spirituality and/or Religious Affiliation

I am of the \_\_\_\_\_ faith and am a member of the \_\_\_\_\_ congregation, parish, synagogue, or worship group in (city) \_\_\_\_\_. The telephone number of the congregation, parish, synagogue, or worship group is: \_\_\_\_\_. Please attempt to notify someone there if I am unable to give authorization to do so.

I am not religious or spiritually affiliated.

## Upon My Death

After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

### • Donation of my Organs or Tissue (Anatomical Gifts)

*Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves. Initial or check the box beside the one statement you agree with.*

After I die, I wish to donate any parts of my body that may be helpful to others. To make your wishes legally effective, register at [www.donorregistry.wisconsin.gov](http://www.donorregistry.wisconsin.gov)

After I die, I wish to donate **only** the following organs and tissue: \_\_\_\_\_

I do not wish to donate any part of my body.

### • Autopsy

*Initial or check the box beside one choice, or both A and B.*

A. I would accept an autopsy if it can help my blood relatives understand the cause of my death or affect their own health care choices.

B. I would accept an autopsy if it can help advance medicine or medical education.

C. I do not want an autopsy performed on me.



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## Part 4: Making the Document Legal

This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below.

### My Signature

**I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.**

My signature \_\_\_\_\_ Date \_\_\_\_\_

If I cannot sign my name, I ask the following person to sign for me \_\_\_\_\_

Signature of the person who I asked to sign this document for me \_\_\_\_\_

### Statement of Witnesses

By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

#### Witness Number One:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

#### Witness Number Two:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

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## Part 5: What to Do Next

Now that you have completed your advance directive, you also should take the following steps:

- Talk to the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of this document.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of this advance directive to your physician. Make sure your wishes are understood and will be followed.
- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:

*Decade* – when you start each new decade of your life.

*Death* – whenever you experience the death of a loved one.

*Divorce* – when your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid. A new document must then be completed.

*Diagnosis* – when you are diagnosed with a serious health condition.

*Decline* – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

- If your wishes change, tell your health care agent, your family, your physician, and everyone who has copies of this advance directive. It would be necessary that you complete a new advance directive to reflect your current wishes.
- Cut out the card on the following page, fill it in, fold it and put it in your wallet.

**Copies of this document have been given to:**

**Primary (Main) Health Care Agent**

Name \_\_\_\_\_

**Alternate Health Care Agent**

Name \_\_\_\_\_

**2<sup>nd</sup> Alternate Health Care Agent**

Name \_\_\_\_\_

**Health Care Professional/Organization**

Name \_\_\_\_\_ Telephone \_\_\_\_\_


Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

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**Need Assistance?**

If you need assistance in completing this document, you may contact:

|  |   |
|--|---|
| <b>I HAVE AN ADVANCE DIRECTIVE</b>   |   |
| Name _____   | <b>Card holder information</b>                |
|  <p><b>Honoring Choices</b><br/><b>WISCONSIN</b><br/>AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY</p> <p><i>The name "Honoring Choices Wisconsin"<br/>is used under license from East Metro Medical Society Foundation.</i></p> | Address _____                                 |
|  | City/state/ZIP _____                          |
|  | Phone _____ Date of birth _____               |
|  | <b>My advance directive is filed at</b> _____ |
|  | Address _____                                 |
| City/state/ZIP _____   |   |
| Phone _____  |   |
| <b>My health care agent is</b> _____   |   |
| Address _____  |   |
| City/state/ZIP _____   |   |
| Phone _____  |   |